Student Insurance Petition to Add Student ONLY Form

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE REVIEWED

Please print clearly to ensure accurate processing. **Date: _____**

Name of College or University: _____

Student's Name: _____ Student ID Number: _____

Address: _____ _____ _____ _____
Street or P.O. Box City State Zip

Gender: _____ **Male** _____ **Female** **Date of Birth: _____ Telephone #: _____**

Email: _____ Student Status: _____ International _____ Domestic

Class Level: _____ Undergraduate _____ Graduate _____ Law _____ Medical

Name of Individual Completing Form: _____
(if other than student)

Relationship to Student: _____

Students can only add coverage if there is a qualifying event. A qualifying event is defined as:

- ✓ Reaching the age limit of another health insurance plan
- ✓ Loss of health insurance through a marriage or divorce
- ✓ Involuntary loss of coverage from another health insurance plan

Please detail your extenuating circumstances explaining the reason you wish to enroll yourself:

_____
_____
_____
_____

I understand that this Petition is subject to the approval of Gallagher Student Health and subject to the payment of any applicable premium. Effective date of coverage will determine premium due. Please see brochure coverage period rates. Premium is not pro-rated. Once your petition has been processed, coverage cannot be cancelled, except for eligibility reasons.

If you are completing this petition as a result of losing coverage under your previous insurance carrier, for whatever reason, you must include a letter from your previous carrier confirming loss of coverage and indicating the last date of coverage. In order not to have a lapse in coverage, this petition must be received within 31 days of your last day of coverage. If this form is not received within 31 days of your last day of coverage, the effective date will be the date that this form is received at Gallagher Student Health.

_____ _____
Signature of Person Completing Form **Date**

Please complete form and return it <u>with a letter from your previous carrier confirming loss of coverage to</u>:
Gallagher Student Health, 500 Victory Road, Quincy, MA 02171 or fax 617-479-0860

Dependent enrollment can be completed by going to: www.gallagherstudent.com

To be completed by Gallagher Student Health

_____ Approved _____ Denied Date: _____ Effective Date: _____ Initials:_____

Revised 2/17/15